



C.L., "BUTCH" OTTER – Governor RICHARD M. ARMSTRONG – Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0000 PHONE 208-334-6626 FAX 208-364-1888

March 9, 2012

Nolan Hoffer, Administrator Southwest Idaho Advanced Care Hospital 6651 West Franklin Road Boise, ID 83709

Provider #132003

Dear Mr. Hoffer:

On February 24, 2012, a complaint survey was conducted at Southwest Idaho Advanced Care Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004983

Allegation #1: The facility failed to involve patients in the development of their plans of care.

Findings #1: An unannounced survey was conducted from 2/21/12 through 2/24/12. Eleven medical records were reviewed, five discharged and six current. Eleven current patients and/or their families were interviewed regarding their care. Medical records were reviewed for documentation of patients being involved in the plan of care through care conferences, special requests, and education. Patients and/or their families were interviewed regarding their involvement in their care decisions and the facility meeting their requests.

Eleven of eleven current patients/family members interviewed stated facility staff involved them in their plans of care. The patients stated facility staff appropriately met their needs and requests.

One medical record reviewed contained documentation of a 48 year old male admitted 3/04/11 to the facility for treatment related to pressure ulcers. Documentation indicated the patient was specifically involved in several areas in the development of his plan of care. For instance, on admission, the patient's provider ordered a specialty STAT III air mattress to assist with preventing further skin breakdown. However, documentation in the medical record indicated the

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patient felt the air mattress was causing increased back pain and muscle spasms. Different pain and muscle relaxant medications, various cushions for comfort, and a Physiotherapist consult were ordered in an attempt to involve the patient in his plan of care. In addition, a different specialty mattress was ordered at the patient's request.

The medical record indicated the patient disliked the facility's food choice, therefore orders were written to allow outside food to be brought in to him.

The medical record contained documentation that the patient had specific time requests for medication administration. The Medication Administration Record (MAR) indicated these requests were accommodated. Throughout the MAR, from admit to discharge, was documentation of the patient exercising his right to refuse medications. For example, the nurses frequently documented the patient refused his bowel medications and even certain muscle relaxants.

The Physician Assistant (PA) involved with the patient's care was interviewed on 2/23/12. She stated the patient was knowledgeable and involved in making decisions regarding his care. She stated the patient was always consulted prior to implementing changes in his treatment. She stated the patient was receptive to trying different treatments, especially related to his back discomfort.

Current medical records contained evidence of patients' requests or specific needs being included in their plans of care. One patient's family stated the facility was providing "excellent care" and were accommodating to their specific needs and special requests, like "actually washing" the patient's hair frequently and adjusting the schedule to meet the patient's desire to sleep in late. Review of the patient's medical record confirmed physician orders to adjust medication and assessment schedules so the patient could sleep in late.

It could not be determined that the facility failed to involve patients' in the development of their plans of care.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Staff failed to meet patients' hygiene needs and keep patients' rooms clean.

Finding #2: An unannounced survey was conducted from 2/21/12 through 2/24/12. Current patients and/or family members and hospital staff were interviewed. Medical records were reviewed and observations were made.

Eleven medical records were reviewed, five for discharged patients and six for current patients.

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Each medical record contained documentation of baths on a daily, or near daily, basis. In addition the medical records contained documentation of additional hygiene performed such as oral care, changing linens, washing face and hands, and care provided after toileting.

Eleven patients and/or their family members were interviewed. Each stated that staff assisted them with all of their hygiene needs from oral care to a complete bath or shower. In addition, patients and family members stated staff were responsive to their requests and needs, such as assisting them with toileting (whether it was a bed pan, bed side commode, or a trip to the toilet) and cleaning them up after. Each patient/family member stated they felt staff responded to their needs appropriately and did not have a complaint related to this issue.

Observations were made 2/21/12 from 9:30 AM to 11:00 AM, 2/22/12 from 8:00 AM to 10:00 AM, 2/23/12 from 1:30 PM to 2:30 PM, and 2/24/12 from 8:45 AM to 10:00 AM. During these time frames, staff were observed to assist patients with hygiene needs such as oral care, washing hands and face before a meal, and preparing patients for a bath or shower. Staff were observed cleaning patient rooms and changing linens and housekeeping was observed mopping floors and emptying trash cans.

A Patient Care Technician was interviewed on 2/21/12 at 10:30 AM. She stated that a patient received a bath or shower each day. She stated she attempted to complete patient baths on the day shift unless the patient requested to bathe in the evening or at night. She stated if she was not able to complete a bath on a patient, the oncoming shift was notified to complete the task. She stated a list was kept at the nurses' station to alert all staff of the patients who still needed to be bathed/showered.

Each occupied patient room had a "DAILY FLOWSHEET TREATMENT RECORD" on a clipboard that the staff used for documentation of care activities which included nutritional/IV intake, bowel and bladder output, position changes, safety and treatments. The treatment records were noted to be current with documentation during each of the observation times that surveyors were present on the unit.

One medical record reviewed contained documentation of a 48 year old male admitted to the facility 3/04/11 for treatment related to pressure ulcers. He was discharged on 3/16/11. The medical record contained documentation of hygiene care on flow sheets and in nursing notes. According to the documentation the patient was given a bed bath and had his linens changed every day of his stay except for one. Documentation also indicated his hair was washed every other day except once. Multiple hygiene cares were documented throughout each day of his stay, including toileting care as needed.

It could not be determined that the facility failed to meet patients' hygiene needs or to keep

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patients' rooms clean.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The facility failed to maintain patients' rights to privacy.

Finding #3: An unannounced survey was conducted from 2/21/12 through 2/24/12. Eleven medical records were reviewed, five for discharged patients and six for current patients. Current patients and/or their family members, as well as staff, were interviewed.

Eleven patients and/or caregivers were interviewed regarding their perception of privacy in the facility. Patients who were interviewed stated their privacy or confidentiality had been protected. They also stated they had not overheard staff talking about other patients.

Eight of the eleven medical records reviewed contained documentation the patient's right to privacy was protected. Three of the medical records contained patient concerns related to potential privacy violations. For example, one medical record reviewed contained a PA's progress note documenting the patient's concern that the facility was monitoring his phone calls. Subsequently, the patient and his family filed a complaint regarding this issue. The facility's documentation of the complaint indicated the concerns were addressed by reassuring the patient/family that "there were no listening devices in any phone in the building" and the facility had "nothing to gain from having bug devices."

While three patients questioned whether their privacy was protected, it could not be determined the facility, in fact, failed to maintain patients' rights to privacy.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Staff failed to address patients'/family members' concerns.

Finding #4: An unannounced survey was conducted from 2/21/12 through 2/24/12. Current patients and/or their family members, as well as staff, were interviewed. Patients' rights information, complaints and grievances, and hospital policies were reviewed.

The hospital's grievance policy indicated that a patient would be notified during the admission process regarding their rights related to complaints and grievances. According to the policy, the information provided to patients included the contact information for the hospital administrator and the patient's case manager, the state survey agency contact information, the process for filing a complaint and/or grievance, and what to expect from the hospital in response to a filed grievance.

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Eleven current patients and/or their family members were interviewed regarding patient's rights issues. Each individual interviewed confirmed they received patient's rights information upon admission and understood their right to file a complaint or grievance. Three of the patients interviewed specifically referenced a patient notebook and located it in their room to demonstrate they had obtained the information.

Documentation from 28 complaints/grievances submitted during the 2011 calendar year were reviewed. The documentation indicated patients' complaints were addressed and resolved appropriately at the time of the complaint. A written notice had been provided if the complaint met the definition of a grievance.

The Director of Quality and Risk Management was interviewed on 2/24/12. She stated if at all possible, she (or another member of the administrative team) would personally meet with patients/family members at the time a complaint was made. She stated during the meeting with the patient/family member she explained her plan of action to address the concern, such as reviewing medical records and interviewing staff. She stated she explained her plan to attain resolution to the concern and asked if the patient/family member was satisfied with the plan. She stated she specifically asked if they would like her to follow up again with the patient/family once the investigation and plan had been completed. She stated most of the time issues were resolved promptly and rarely became an actual grievance.

One medical record reviewed contained documentation of a 48 year old male admitted to the facility on 3/04/11 for treatment related to pressure ulcers. He was discharged on 3/16/11. A nursing progress note on 3/13/11 stated the patient was requesting to speak with the Director of Nursing and the provider. The PA documented the patient's concerns and discussion regarding the issues in a progress note. However, the patient's/family's concerns did not seem to resolve from the discussion and a complaint was filed.

Complaint documentation of this incident included who was involved in the discussion of the patient's/family's concerns and how the concerns were addressed and resolved. Documentation indicated the patient/family expressed concerns regarding the facility not providing adequate hygiene needs, the food not being up to standards, and being on too many medications. In response, the Director of Nursing documented that the PA reviewed each of the medications the patient was on with the patient and his family. The PA was also documented as discussing the importance of the air mattress for preventing further skin breakdown, but based on the patient's concerns, a Clinitron mattress had been ordered by the physician. Also documented was reassurance the night shift staff would be instructed to ensure the patient was turned every 2 hours. The Director of Nursing also documented she gave the patient spicy condiments to keep in his room, to help with the taste of the food. The patient was also given a bed bath and had his

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hair washed.

It could not be determined that the facility failed to have an effective complaint/grievance process.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: Staff failed to provide interventions for preventing skin breakdown.

Finding #5: An unannounced survey was conducted from 2/21/12 through 2/24/12. Eleven medical records were reviewed, five for discharged patients and six for current patients. Eleven currents patients and/or their families were interviewed regarding their care. Medical records were reviewed for documentation of appropriate repositioning, skin care, wound care orders and treatment, and mattresses. Patients and/or their families were interviewed regarding skin care, turning frequency, and the use of mattresses.

Observations were made on 2/21/12 from 9:30 AM to 11:00 AM, 2/22/12 from 8:00 AM to 10:00 AM, 2/23/12 from 1:30 PM to 2:30 PM, and 2/24/12 from 8:45 AM to 10:00 AM on the facility's patient care unit. While observing staff responding to call lights, surveyors also checked on patients at various times to assess for position changes. Patients were found to be repositioned at appropriate intervals. Flow sheets for documenting skin cares and repositioning were in patients' rooms and were updated throughout the day.

The five discharged records reviewed included documentation that indicated wounds were healing, skin integrity was maintained, and in some cases, skin integrity was improving. The six current records reviewed included documentation of scheduled repositioning every 2 hours, appropriate hygiene, use of specialty mattresses as appropriate, and physician ordered wound care.

Eleven of eleven current patients interviewed stated facility staff turned and repositioned them appropriately and per request. The patients stated staff provided appropriate wound care, skin care, repositioning, and hygiene needs to keep the patients' skin intact and, in some cases, healing.

The Medical Director was interviewed on 2/23/12 regarding the use of different mattresses to prevent skin breakdown. He stated the STAT III air mattress was used for patients at high risk of developing pressure ulcers and for patients who already had pressure ulcers, while the Clinitron mattress was used for patients recovering from a skin flap placement and who were "extremely immobile." He stated the Clinitron mattress contained sand beads blown around by a warm air fan and does not require repositioning to maintain skin integrity.

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One medical record reviewed contained documentation of a 48 year old male admitted to the facility on 3/04/11 for treatment related to pressure ulcers and was discharged 3/16/11. The STAT III air mattress was ordered on admission as the patient already had pressure ulcers. The patient was documented as wearing Prevalon boots (padded boots to protect the heels from skin breakdown). The medical record also contained documentation of staff applying barrier cream to the patient's coccyx. Documentation on the MAR indicated staff were turning the patient every two hours while on the STAT III air mattress and per the patient's request while on the Clinitron mattress.

The PA involved in the patient's care was interviewed on 2/23/12. She stated the patient was admitted with a Stage IV (all layers of skin and muscle involved) pressure ulcer and had quadriplegia. She stated the patient wanted a "regular mattress," but that medically, he needed to be on the specialty STAT III air mattress to allow the pressure ulcer to heal and to prevent further skin breakdown. She stated the physician agreed to try a Clinitron mattress as an alternative to the air mattress, even though the patient's condition did not warrant an upgrade to this type of mattress.

It could not be determined the facility failed to provide interventions for preventing skin breakdown.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: Staff failed to answer call lights and respond to patient needs in a timely manner.

Finding #6: An unannounced survey was conducted from 2/21/12 through 2/24/12. Complaint/grievance documentation was reviewed and observations were conducted. Staff and patients/family members were interviewed.

Eleven current patients/family members were interviewed between 2/21/12 and 2/23/12. Each individual stated they were satisfied with the response of staff when they turned on the call light. Each individual stated that staff attended to their needs and requests in a timely manner and with a cooperative demeanor.

Observations were made 2/21/12 from 9:30 AM to 11:00 AM, 2/22/12 from 8:00 AM to 10:00 AM, 2/23/12 from 1:30 PM to 2:30 PM, and 2/24/12 from 8:45 AM to 10:00 AM. During these time frames, staff were observed responding to call lights. On 2/21/12 between 9:36 AM and 9:50 AM, staff were observed responding to multiple call lights and a patient who presented to the nursing station. The Unit Secretary was observed to speak directly with the patient's room via telephone to determine what the request was. She was then observed using a two-way radio

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to contact either nursing or Patient Care Technician staff to respond to the request. She was observed to contact staff a second time within 2-3 minutes if the call light was still alarming. All call lights were observed to be responded to within five minutes during this observation period.

A Patient Care Technician was interviewed on 2/21/12 at 10:30 AM. She stated that while at times staff were busy, she felt patients' needs were always attended to in a timely manner. She stated staff worked together well to provide the tasks needed in order to accomplish excellent patient care.

During an interview on 2/24/12 at 3:00 PM, the Chief Executive Officer explained that the facility had a system in place to track staffs' response times to call lights for analysis. He stated the only way a call light could be turned off was when staff responded to the room and turned it off from there.

Complaint/grievance documentation was reviewed for the 2011 calendar year. Five out of 28 registered concerns related to timeliness of responding to call lights. However, there have been no complaints/grievances related to this since 8/2011.

One complaint reviewed included concerns by the patient/family that staff had left the patient laying in his own urine and feces for "upwards of 4 hours." It could not be verified through the investigation process that this occurred.

It could not be determined the facility failed to answer call lights in a timely manner.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #7: The facility failed to address patients' dietary needs and/or requests.

Finding #7: An unannounced survey was conducted from 2/21/12 through 2/24/12. Eleven medical records were reviewed, five for discharged patients and six for current patients. Eleven current patients and/or their family members, as well as staff, were interviewed.

Eleven current patients and/or their family members were interviewed regarding dietary concerns. They were questioned on quality of food, dietary preferences, and availability for flexibility to meet special requests. The patients and family members expressed satisfaction with the quality, food choices, and the availability of the dietary department with meeting their needs. Multiple staff members were interviewed, and indicated the facility attempts to meet the nutritional needs of their patients.

In an interview on 2/24/12 at 11:45 AM, the Dietary Manager stated patient dietary needs, which

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include religious restrictions, will often be relayed by the referral facility, before the patient's admission to the facility. In addition, the Dietary Manager stated the dietician performs a nutritional needs assessment on all patients within 72 hours of admission, and special nutritional needs will be identified at that time, if not before.

A policy, titled "Meals and Food Service," dated 10/07, stated "Patient cultural or religious considerations will be taken into account with any diet (i.e., kosher diet, vegetarian) and any dietary substitutions are made available, if the diet order allows."

One medical record documented a 48 year old male admitted to the facility on 3/04/11 for treatment of pressure ulcers and discharged on 3/16/11. A physician order was written 3/08/11 to allow the patient to eat food from the outside. On 3/10/11, the PA documented of the patient, "No complaints (except food)". On 3/13/11, the PA documented the patient complained of the "bad food."

This patient filed a complaint regarding the quality of the food not being "up to his standards" on 3/13/11. The resolution documented for this complaint included that the Director of Nursing provided the patient with Jalapenos, Tabasco sauce, hot sauce, salt, and pepper to help improve the taste of his food.

It could not be determined the facility failed to address patients' dietary needs and/or requests.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

AIMEE HASTRITER Health Facility Surveyor

Non-Long Term Care

SYLVIA CRESWELL

Co-Supervisor

Non-Long Term Care

AH/srm





C.L. "BUTCH" OTTER – Governor RICHARD M. ARMSTRONG – Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720-0009 Boise, ID 83720-0009 PHONE 208-334-6626 FAX 208-364-1888

March 9, 2012

Nolan Hoffer, Administrator Southwest Idaho Advanced Care Hospital 6651 West Franklin Road Boise, ID 83709

Provider #132003

Dear Mr. Hoffer:

On **February 24, 2012**, a complaint survey was conducted at Southwest Idaho Advanced Care Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005014

Allegation #1: Patient privacy and confidentiality was not maintained.

Finding #1: An unannounced survey was conducted from 2/21/12 through 2/24/12. During the investigation, eleven patient records were reviewed. Observations were conducted and staff and patients/family members were interviewed.

Between 2/21/12 and 2/23/12, eleven patients/caregivers were interviewed regarding their perception of privacy in the facility. All individuals interviewed stated they did not feel their privacy or confidentiality had been violated. Patients confirmed that they had not heard any patient confidential information or seen patients privacy violated.

Observations were made on 2/21/12 from 9:30 AM to 11:00 AM, 2/22/12 from 8:00 AM to 10:00 AM, 2/23/12 from 1:30 PM to 2:30 PM, and 2/24/12 from 8:45 AM to 10:00 AM. Staff were observed in their communications between each other and patients. Patient confidentiality was maintained by not disclosing patient names or private information and closing doors and curtains when patient care was provided.

Eleven medical records were reviewed. Five of these records were for discharged patients and six of the records were for current patients. All of the medical records contained documentation of assessments completed by appropriate staff members. Of the eleven medical records reviewed, three of the records

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contained documentation of staff addressing patient concerns related to the violation of patient privacy. For example, one medical record contained documentation for the admission of a female who received treatment for a heel wound, congestive heart failure, and chronic obstructive pulmonary disease. Her medical record contained documentation from nursing assessments and interactions, consultations with a wound care specialist and psychiatrists, and social services staff.

The initial nursing assessment was completed by a registered nurse late on a Friday afternoon. She was also assessed by a respiratory therapist and a dietician that same day. The following Monday she was evaluated by physical and occupational therapists.

Her medical record contained documentation from a psychiatric consult completed on the fourth day of her admission. The psychiatrist documented "...patient was seen with physician's assistant student. She was in physical therapy. Examination was undertaken in the physical therapy setting as there were no other patients within earshot and a table was available for the patient, therefore she would be more comfortable completing the cognitive instruments than in her hospital bed." The psychiatrist also documented, "It should be noted that patient apparently reported to physical therapy that she was humiliated at having undergone assessment with the (psychiatric testing) in the physical therapy room, and reported became extremely tearful and had to be escorted back to her room. However, moments later when seen by the undersigned, patient was euthymic and simply requested assistance with bowel movement, eye contact within normal limits, in no acute distress. She also had been euthymic at the end of the examination in the PT (physical therapy) gym."

In addition, her medical record contained a second psychiatric assessment completed two and a half weeks after her admission. The psychiatrist documented in his progress note that the patient was "...angry and hostile as soon as I walked in the door, refusing to talk to me...I told her that I was there to help and that we were concerned about her...She did end up talking to me a little bit..." Nursing documentation later that same day indicated that the patient had spoken to someone in administration regarding an "...unidentified man...(who) barged in here in front of everyone and started asking me questions..."

The Director of Quality and Risk Management was interviewed on 2/24/12 at 10:35 AM. She confirmed that the above medical record did not contain documentation of the conversation between anyone in administration and the patient regarding the patient's concern of invasion of privacy during psychiatric evaluations. The Director of Quality and Risk Management stated she typically kept her own notes but explained that the administrator who handled this issue was no longer working in an administrative position and she was not sure if any documentation was maintained.

While patients voiced concerns about the violation of privacy, it could not be determined that patient's privacy and confidentiality were not maintained.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Staff failed to meet patients' hygiene needs.

Finding #2: An unannounced survey was conducted from 2/21/12 to 2/24/12. Current patients/family

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members and hospital staff were interviewed. Medical records were reviewed and observations were made.

Eleven medical records were reviewed. Five of these records were for discharged patients and six of the records were for current patient. Each medical record contained documentation of baths on a daily, or near daily, basis. The medical records also contained documentation of hygiene performed more than once a day, such as oral care, changing linens, washing face and hands, and care provided after toileting.

Eleven patients and/or their family members were interviewed between 2/21/12 and 2/23/12. Each individual stated that staff assisted them with all of their hygiene needs from oral care to a complete bath or shower. In addition, patients and family members stated staff were responsive to their requests and needs, such as assisting with toileting (whether it was a bed pan, bed side commode, or a trip to the toilet) and cleaning up after. Each patient/family member stated they felt staff responded to their needs appropriately and did not have a complaint related to this issue.

Observations were made 2/21/12 from 9:30 AM to 11:00 AM, 2/22/12 from 8:00 AM to 10:00 AM, 2/23/12 from 1:30 PM to 2:30 PM, and 2/24/12 from 8:45 AM to 10:00 AM. During these time frames, staff were observed to assist patients with hygiene needs such as oral care, washing hands and face before a meal, preparing patients for a bath or shower, and assisting them with toileting needs. Staff were observed cleaning patient rooms and changing linens.

A Patient Care Technician was interviewed on 2/21/12 at 10:30 AM. She stated patients received a bath or shower each day. She stated the aides attempted to complete patient baths on the day shift unless the patient requested to bath in the evening or at night. She stated if she was not able to complete a bath on a patient the oncoming shift was notified to complete the task. She explained a list was kept at the nurse's station to alert all staff of the patients who still needed to be bathed/showered.

Each occupied patient room had a "DAILY FLOWSHEET TREATMENT RECORD" on a clipboard that the staff used for documentation of care activities which included nutritional/IV intake, bowel and bladder output, position changes, safety and treatments. The treatment records were noted to be current with documentation during each of the observation times that surveyors were present on the unit.

One medical record contained documentation for the admission of a female who received treatment for a heel wound, congestive heart failure, and chronic obstructive pulmonary disease. Her medical record contained documentation of a bath and/or hygiene care including oral care, washing her face, and cleaning her peri area (after the patient used the toilet) daily. Oral care, face cleansing, and pericare were occasionally documented as completed multiple times a day. Staff documented when the patient refused assistance with hygiene.

It could not be determined that staff failed to meet patients' hygiene needs.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Care was not provided in accordance with the Plan of Care.

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Finding #3: An unannounced survey was conducted from 2/21/12 through 2/24/12. Medical records were reviewed and staff and patients/family members were interviewed.

Between 2/21/12 and 2/23/12, eleven current patients/family members were interviewed regarding patient involvement with the Plan of Care. Each individual stated they felt involved in the development of their care plan from medication administration to provision of therapy services. Everyone felt that services were being provided in accordance with the Plan of Care developed by the team involved in their care.

Eleven medical records were reviewed. Five of these records of were for discharged patients and six of the records were for current patients. Records contained documentation of a Plan of Care developed by all services involved in treating the patient, including the patient, nursing services, nutritional services, speech, respiratory, physical, and occupational therapy, the primary and consulting physicians, and social services. The records contained documentation that care was provided in accordance to the developed Plan of Care.

One medical record contained documentation for the admission of a female who received treatment for a heel wound, congestive heart failure, and chronic obstructive pulmonary disease. The initial orders obtained on her admission day, written late in the afternoon on Friday, included orders for physical therapy and occupational therapy evaluations. The Physical Therapist and Occupational Therapist completed their evaluations and developed plans of care on Monday morning, three days after her admission. Her medical record contained assessments from physicians, nurses, the dietician, and physical and occupational therapy. The medical record contained documentation of a Plan of Care developed based on these assessments.

According to the patient's Plan of Care, she was to receive occupational therapy sessions 1-2 times a day 3-5 times a week and physical therapy sessions 1 time a day 3-5 times a week. The medical record contained documentation of occupational therapy services conducted and/or offered 1-2 times a day 3-5 times a week. The record also contained physical therapy service documentation of sessions conducted and/or offered 1 time a day 3-5 times a week.

It could not be determined that care was not provided in accordance with the plan of care.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Staff failed to address the concerns of patients/family members.

Finding #4: An unannounced survey was conducted 2/21/12 through 2/24/12. Current patients and/or their family members, as well as staff, were interviewed. Patients' rights information, complaints and grievances, and hospital policies were reviewed.

The hospital's grievance policy indicated that a patient would be notified during the admission process regarding their rights related to complaints and grievances. According to the policy the information provided to patients included the contact information for the hospital administrator and the patient's case manager, the state survey agency contact information, the process for filing a complaint and/or grievance,

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and what to expect from the hospital in response to a filed grievance.

Eleven current patients and/or their family members were interviewed, between 2/21/12 and 2/23/12, regarding patients' rights issues. Each individual interviewed confirmed they received patient's rights information upon admission and understood their right to file a complaint or grievance. Three of the patients interviewed specifically referenced a patient notebook and located it in their room to demonstrate they had obtained the information.

Documentation from 28 complaints/grievances submitted during the 2011 calendar year were reviewed. The documentation indicated patients' complaints were addressed and resolved at the time of the complaint. A written notice had been provided if the complaint met the definition of a grievance.

The Director of Quality and Risk Management was interviewed on 2/24/12. She stated if at all possible, she (or another member of the administrative team) would personally meet with patient/family member at the time a complaint was made. She stated during the meeting the with patient/family members she explained her plan of action to address the concern, such as reviewing medical records and interviewing staff. She stated she explained her plan to attain resolution to the concern and asked if the patient/family member was satisfied with the plan. She stated she specifically asked if they would like her to follow up again with the patient/family once the investigation and plan had been completed. She stated most of the time issues were resolved promptly and rarely became an actual grievance.

One medical record contained documentation for the admission of a female who received treatment for a heel wound, congestive heart failure, and chronic obstructive pulmonary disease. Her medical record contained several instances when concerns related to care issues were communicated to staff.

For example, the patient was examined by a psychiatrist on the fourth day of her admission. The consultation note dictated by the psychiatrist indicated "...patient was seen with physician's assistant student. She was in physical therapy. Examination was undertaken in the physical therapy setting as there were no other patients within earshot and a table was available for the patient, therefore she would be more comfortable completing the cognitive instruments than in her hospital bed...It should be noted that patient apparently reported to physical therapy after her examination that she was humiliated at having undergone assessment...in the physical therapy room, and reportedly became extremely tearful and had to be escorted back to her room. However, moments later when seen by the undersigned, patient was euthymic and simply requested assistance with bowel movement, eye contact within normal limits, in no acute distress. She also had been euthymic at the end of the examination in the PT (###) gym." Staff notified the physician upon receipt of the complaint to facilitate a resolution.

In addition, nursing documentation indicated that the patient spoke with administration at least three times during her admission related to concerns, and spoke with either the charge nurse or the house supervisor on several other occasions. In each instance the concerns were resolved in a timely manner.

It could not be determined that staff failed to address the concerns of patients/family members.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

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As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

AIMEE HASTRITER Health Facility Surveyor Non-Long Term Care SYLVIA CRESWELL

Co-Supervisor

Non-Long Term Care

AH/srm





March 16, 2012

Ms. Aimee Hastriter Bureau of Facility Standards 3232 Elder St. P.O. Box 83720 Boise, ID. 83720-0009

RE: Southwest Idaho Advanced Care Hospital, Provider #132003

Dr. Ms. Hastriter,

Enclosed please find our comprehensive action plan to assure ongoing compliance and process improvement for the area in which we were found deficient. If you have any questions, please feel free to contact me.

Sincerely,

Nolan L. Hoffer,

NLH/nlh

Cc: File





DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		132003	B. WIN	1G _		1	2 4/2012
	ROVIDER OR SUPPLIER	CED CARE HOSPITAL	•	6	REET ADDRESS, CITY, STATE, ZIP CODE 651 WEST FRANKLIN ROAD BOISE, ID 83709		
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A 000	A 000 INITIAL COMMENTS The following deficiencies were cited during the		A	000			
	The surveyors cond				RECEI MAR 1 &	VE 2012	
The following acronym was used in this report:				FACILITY STA	NDARD	S	
A 450	PA - Physician Assistant 482.24(c)(1) MEDICAL RECORD SERVICES All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure dictated documentation in the medical record was authenticated by the person responsible for providing the service for 1 of 11 patients (#3) whose record was reviewed. This failure in the dictation/transcription system had the potential to impact the medical records of all patients cared for at the facility. Lack of an appropriately authenticated document led to an inaccurate		A	450	Action: A review of processes was completed with the transcript service regarding the identification of the practitioner dictating hand physicals, progress notes consultations, procedure noted discharge summaries on 02/2 Implementation of electronic mechanisms and identification person completing the dictation put into place on 03/01/2012 addition, the inclusion of the supervising practitioner signar requirement on any documents.	cation history s, es and 27/2012 on of the ions was d. In	
ARODATOR	the hospital on 3/25 wound on her heel, chronic obstructive	O year old female admitted to 5/11 for care related to a congestive heart failure, and pulmonary disease. She was	NATURE		was implemented in those ca required by practitioner delin privileges.		(X6) <u>5</u> ATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient projection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRU A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER SOUTHWEST IDAHO ADVANCED CARE HOSPITAL					REET ADDRESS, CITY, STATE, ZIP CODE 651 WEST FRANKLIN ROAD FOISE, ID 83709		
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		132003		B. WING _		1	1/2012
NAME OF PROVIDER OR SUPPLIER SOUTHWEST IDAHO ADVANCED CARE HOSP (X4) ID PREFIX TAG B 000 16.03.14 Initial Comments The following deficiencies were cited complaint investigation of your hospital Surveyors conducting the on-site visit Aimee Hastritier, RN, BS, HFS, Team Suzi Costa, RN, HFS Karen Robertson, RN, BSN, HFS BB284 16.03.14.360.13 Signature on Record 13. Signature on Records shall be noted as follows: (10.00.10 a. Every physician shall sign and date which that physician makes, or directs made.		STREET ADD	DRESS, CITY, S	STATE, ZIP CODE			
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	Suzi Costa, RN, HF	S	eader				
BB284	16.03.14.360.13 Si	gnature on Records		BB284	BB284		
	13. Signature on Records. Signatures on medical records shall be noted as follows: (10-14-88)				Repeat A 450 Action		
	a. Every physician shall sign and date the entries which that physician makes, or directs to be made. (10-14-88)						
	b. A single signature on the face sheet record does not authenticate the entire record. (10-14-88)				RECEIV	EM	
c. Any person writing in a medic sign his name to enable positive name and title. (10-14-88)		nable positive identifi					
	d. If initials are used, an identifying signature shall appear on each page. (10-14-88)				FACILITY STANI	DARDS	
	e. Rubber stamp signatures can be used only by the person whose signature the stamp represents. A signed statement to this effect shall be placed on file with the hospital administrator. (10-14-88)						
		stigation of your hospital. ducting the on-site visit were: ar, RN, BS, HFS, Team Leader I, HFS Dn, RN, BSN, HFS 3 Signature on Records BB284 Repeat A 450 Action BB284 Repeat A 450 Action Records signatures on medical an oted as follows: (10-14-88) attrian shall sign and date the entries sician makes, or directs to be atture on the face sheet record niticate the entire record. Avriting in a medical record shall to enable positive identification by (10-14-88) aused, an identifying signature shall in page. (10-14-88) App signatures can be used only by use signature the stamp igned statement to this effect shall					

Bureau of Facility Standards

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documentation in the medical record needing to be authenticated by the person responsible for

STATE FORM

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Bureau of Facility Standards

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Bureau of Facility Standards





C.L. "BUTCH" OTTER – Governor RICHARD M. ARMSTRONG – Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0009 PHONE 208-334-6626 FAX 208-364-1888

March 21, 2012

Nolan Hoffer, Administrator Southwest Idaho Advanced Care Hospital 6651 West Franklin Road Boise, ID 83709

Provider #132003

Dear Mr. Hoffer:

On February 24, 2012, a complaint survey was conducted at Southwest Idaho Advanced Care Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005026

Allegation #1: Patients' rights to privacy were not maintained.

Findings #1: An unannounced visit was made to the facility on February 21 through February 24, 2012. During the complaint investigation, surveyors reviewed eleven patient records, including five records of discharged patients and six records of current patients. Administrative documents were reviewed, including hospital policies, incident reports, and documentation of patient complaints and grievances. Physical therapy and occupational therapy services were observed being provided to multiple patients. Nursing staff, therapy staff, a pharmacist, and administrative staff were interviewed.

Eleven patients and/or caregivers were interviewed regarding their perception of privacy in the facility. Patient's who were interviewed stated they did not feel their privacy or confidentiality had been violated.

The general floor for the majority of patients had private rooms with the head of bed positioned against the head wall. Visibility of patients would be possible if the patient door was open and one was passing by the open room. It was not possible to visualize a patient in another room

Nolan Hoffer, Administrator March 21, 2012 Page 2 of 5

while inside a patient's room.

One record documented a patient who complained of witnessing another patient exposing himself while in another patient room. The record indicated the patient was relocated the same day the incident was reported to the staff.

In an interview on 2/23/12 at 11:45 AM, the Director of Quality and Risk Management stated there was a possibility of two rooms on the unit where it would be possible to see into the other room if both doors were open and the patients were "in the right spot" in each room, but not from the beds.

It could not be determined that the facility failed to protect patients' privacy.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The facility failed to address dietary needs/requests.

Findings #2: Eleven patients and/or family members were interviewed regarding dietary concerns. They were questioned on quality of food, dietary preferences, and the staffs' ability to meet special requests. The patients and family members expressed satisfaction with the quality, food choices, and the responsiveness of the dietary department in meeting their needs. Multiple staff members were interviewed, and indicated the facility attempted to meet the nutritional needs of the patients. (At the time of the investigation, there were no patients at the facility with religious dietary restrictions.) Three meals were observed, and staff was noted to assist patients with set up and/or feeding assistance.

One patient record contained documentation the physician had ordered a regular diet (which meant no restrictions). The Plan of Care indicated the patient had dietary restrictions based on religion. The medical record contained documentation that the dietary staff had purchased foods specific to the request of the patient, from the market the patient had requested. In addition, the patient was noted to need assistive devices to allow for self feeding.

In an interview on 2/24/12 at 11:45 AM, the Dietary Manager stated patient dietary needs, including religious restrictions, were usually relayed by the referral facility. In addition, the Dietary Manager stated the dietician will perform a nutritional needs assessment on all patients within 72 hours of admission, and special nutritional needs will be identified at that time, if they were not before.

In an interview on 2/23/12 at 9:15 AM, the Director of Quality and Risk Management reviewed the patient record and stated she remembered the individual. She stated attempts were made to

Nolan Hoffer, Administrator March 21, 2012 Page 3 of 5

secure the desired foods for the patient as well as, his eating utensils. The Director of Quality and Risk Management stated the patient had verbalized a fear of loosing the utensils if brought from home, and refused to use the ones provided by the facility. She stated the patient had gone on a "hunger strike" which complicated the ability of the facility to meet his nutritional needs.

A policy, titled "Meals and Food Service," dated 10/07, stated "Patient cultural or religious considerations will be taken into account with any diet (i.e., kosher diet, vegetarian) and any dietary substitutions are made available, if the diet order allows."

It could not be determined that the facility failed to address and meet the patients' nutritional needs.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Nursing staff failed to develop a comprehensive Plan of Care.

Findings #3: Eleven patients and/or family members were interviewed regarding patient involvement with the Plan of Care. Patients were queried about care conferences, patient care, and therapy routines. There were no concerns discussed by patients regarding the Plan of Care (POC) not being followed. Ten medical records contained documentation in the POC and progress notes that assistive devices were utilized and incorporated into the POC.

One patient record documented a patient who required the use of a wheelchair for mobility, and specialty boots were documented as in place on only two days of the "DAILY FLOWSHEET TREATMENT RECORD." However, there were no physician orders on admission to the facility for the use of the specialty boots, nor was it in the nursing or physical therapy assessments on the day of admission. In a review of the discharge orders from the referral facility, there was an order for "Prevalon boots to feet." The POC for the patient did not include the use of Prevalon boots.

In an interview on 2/24/12 at 9:00 AM, the Interim Director of Nursing (DON) stated if the boots had not been ordered by the physician or physical therapy, the boots would not be necessarily be included in the plan of care. She stated the inconsistent documentation of the boots being worn by the patient was a result of them not being included in the plan of care. The DON stated if a patient had an assistive device that was being used prior to hospitalization, there would not always be an order for the use of that device, and that orders were usually for new patient appliances. In addition, the DON stated the POC or nursing assessment should have included the boots as an assistive device.

The facility failed to include assistive device in the POC and ensure the use thereof. The facility,

Nolan Hoffer, Administrator March 21, 2012 Page 4 of 5

at the time of the survey, demonstrated the current patients' POC's were comprehensive and included assistive devices and equipment.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: The facility misappropriated a patient's own medications.

Findings #4: Eleven patients and/or family members were interviewed regarding bringing in own medications from home. None of the patients interviewed brought in their medications from home. Three staff members and a facility pharmacist were interviewed. The staff nurses who were interviewed stated patients and family are questioned during the admission process if medications have been brought in. If so, they would be either sent home or the medication would be verified by the pharmacist and stored in the pharmacy until the patient was discharged.

One patient record indicated over the counter medications and a narcotic medication were found in the patient's room. The record contained documentation the medications were counted and stored in the pharmacy until that patient was discharged.

During an interview on 2/23/12 at 3:00 PM, a facility Pharmacist stated patient medications were held in the pharmacy until the patient discharge. The Pharmacist stated she had been aware of the particular patient and medications brought to the pharmacy, but had not been personally involved in the case.

A form, titled "PATIENTS OWN MEDICATION HELD IN PHARMACY LOG," was provided by the Pharmacist. The form included the patient name, the medication received by the pharmacy, the number of pills counted, date, and the pharmacist initials, as well as the date the medication was returned to the patient, with initials.

In the case of the patient whose record was reviewed, the log documented the amount of medication that was noted and stored by the pharmacy, which was documented by two pharmacy staff.

It could not be determined the facility misappropriated patient medications.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: Facility did not manage patient's pain.

Findings #5: Eleven patients and/or family members were interviewed regarding pain management. None of the patients interviewed complained about the facility not meeting the

Nolan Hoffer, Administrator March 21, 2012 Page 5 of 5

patients' needs for pain control.

One patient record documented multiple diagnoses, one of which was chronic pain syndrome. One of the long term goals identified before admission was pain management. Pain medications written on the date of admission to the facility included OxyContin 30 mg twice daily and Dilaudid 4 mg every four hours as needed for severe pain. The discharge orders for pain medication were the same as the admission orders.

The patient record indicated the patient developed respiratory difficulties, was transferred to the high observation unit and placed on a device to assist with breathing. Documentation by a physician indicated the respiratory difficulties were the result of narcotic overdose. Changes to the pain medication orders were made, which kept the dosages the same, but included parameters to hold the dose for respiration rate less than 12 or evidence of excessive sedation.

Review of the patient's "PRN INTERVENTION FORM," which included when a pain medication was given, the patient pain level before and after receiving the medication and other comments, indicated the patient had effective pain relief.

The allegation that the facility failed to manage the patient's pain was unsubstantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

/sc

Sincerely,

AIMEE HASTRITER Health Facility Surveyor

Non-Long Term Care

SYLVIA CRESWELL

Co-Supervisor

Non-Long Term Care

AH/srm





C.L. "BUTCH" OTTER – Governor RICHARD M. ARMSTRONG – Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720-0009 Boise, ID 83720-0009 PHONE 208-334-6626 FAX 208-364-1888

March 9, 2012

Nolan Hoffer, Administrator Southwest Idaho Advanced Care Hospital 6651 West Franklin Road Boise, ID 83709

Provider #132003

Dear Mr. Hoffer:

On February 24, 2012, a complaint survey was conducted at Southwest Idaho Advanced Care Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005061

Allegation #1: Staff failed to meet patients' hygiene needs.

Finding #1: An unannounced survey was completed from 2/21/12 through 2/24/12. During the complaint investigation, surveyors reviewed eleven patient records, including five records of discharged patients and six records of current patients. Administrative documents were reviewed, including hospital policies, incident reports, and documentation of patient complaints and grievances. Physical therapy and occupational therapy services were observed being provided to multiple patients. Staff and patients/family members were interviewed.

Eleven patients and/or their family members were interviewed. Each individual stated that staff assisted them with all of their hygiene needs from oral care to a complete bath or shower. In addition, patients and family members stated staff was responsive to their requests and needs, such as assisting them to toilet (whether it was a bed pan, bed side commode, or a trip to the toilet) and cleaning them up after. Each patient/family member stated they felt staff responded to their needs appropriately and did not have a complaint related to this issue.

Observations were made 2/21/12 from 9:30 AM to 11:00 AM, 2/22/12 from 8:00 AM to 10:00

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AM, 2/23/12 from 1:30 PM to 2:30 PM, and 2/24/12 from 8:45 AM to 10:00 AM. During these time frames, staff was observed to assist patients with hygiene needs such as oral care, washing hands and face before a meal and preparing patients for a bath or shower. Staff was observed cleaning patient rooms and changing linens.

A Patient Care Technician was interviewed on 2/21/12 at 10:30 AM. She stated that a patient received a bath or shower each day. She stated she attempted to complete patient baths on the day shift unless the patient requested to bath in the evening or at night. She stated if she was not able to complete a bath on a patient the oncoming shift was notified to complete the task. She stated a list was kept at the nurse's station to alert all staff of the patients who still needed to be bathed/showered.

Each occupied patient room (except those in the high observation unit) had a "DAILY FLOWSHEET TREATMENT RECORD" on a clipboard that the staff used for documentation of care activities which included hygiene, nutritional/intravenous intake, bowel and bladder output, position changes, safety and treatments. The treatment records were noted to be current with documentation during each of the observation times that surveyors were present on the unit.

Each medical record contained documentation of hygiene needs being attended to, such as assisting with bathing, toileting, and oral care. One record documented an 82 year old male who was admitted to the hospital on 4/07/11. The patient had multiple medical complications as well as a tracheostomy, peripherally inserted central catheter (a long term intravenous line) and urinary catheter. The medical record contained documentation of patient bathing each day of his five week hospital admission, with the exception of three days. The medical record also contained documentation of the provision of oral care and additional care cleaning up after incontinent episodes.

It could not be determined that the facility failed to meet the hygiene needs of the patient.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Staff failed to respond to patients' or family members' concerns.

Findings #2: An unannounced survey was conducted from 2/21/12 through 2/24/12. Current patients and/or their family members, as well as staff, were interviewed. Patients' rights information, complaints and grievances, and hospital policies were reviewed.

The hospital's grievance policy indicated that a patient would be notified during the admission process regarding their rights related to complaints and grievances. According to the policy the information provided to patients included the contact information for the hospital administrator and the patient's case manager, the state survey agency contact information, the process for filing

Nolan Hoffer, Administrator March 9, 2012 Page 3 of 7

a complaint and/or grievance, and what to expect from the hospital in response to a filed grievance.

Eleven current patients and/or their family members were interviewed regarding patients' rights issues. Each individual interviewed confirmed they received patients' rights information upon admission and understood their right to file a complaint or grievance. Three of the patients interviewed specifically referenced a patient notebook and located it in their room to demonstrate they had obtained the information.

Documentation from 28 complaints/grievances submitted during the 2011 calendar year were reviewed. The documentation indicated patients' complaints were addressed and resolved appropriately at the time of the complaint. A written notice had been provided if the complaint met the definition of a grievance.

One complaint reviewed was for a patient whose family member had requested to speak with the Director of Quality and Risk Management. In the complaint, the family member voiced concerns in three areas. The initial concern was that the patient had restraints on both hands and was in a room with the door closed. The patient had removed the gown and the sheet was off the bed, in addition, upon opening the door to the room, the family member noted the patient had both legs over the side rail of the bed. The second concern expressed in the complaint was regarding a pain medication that had been delayed. The third concern was the patient had been found on another day with a damp towel on the bed. The complaint form was completed by the Director of Quality and Risk Management, and the section "Resolution/Actions," indicated the discussion with the patient's family member had resulted in a resolution, with a notation of satisfaction expressed by the family member.

The Director of Quality and Risk Management was interviewed on 2/24/12. She stated if at all possible, she (or another member of the administrative team) would personally meet with patients/family members at the time a complaint was made. She stated as part of her investigation into concerns, she first interviewed the patient/family member. She stated that after listening to the patient's/family member's concerns, she would then speak with staff, review the medical record, and follow up with any additional investigation needed. She stated at the time of the initial conversation with the patient/family member she explained her plan of action to address the concern. She stated she explained her plan to attain resolution to the concern and asked if the patient/family member was satisfied with the plan. She stated she specifically asked if they would like her to follow up again with the patient/family once the investigation and plan had been completed. She stated most of the time issues were resolved promptly and rarely became an actual grievance.

It could not be determined that the facility failed to have an effective complaint/grievance process.

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Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The facility failed to address dietary needs.

Findings #3: An unannounced survey was completed from 2/21/12 through 2/24/12. Eleven patient records, including five records of discharged patients and six records of current patients were reviewed. Administrative documents were reviewed, including hospital policies, incident reports, and documentation of patient complaints and grievances. Staff and patients/family members were interviewed.

Eleven patients and/or family members were interviewed regarding dietary concerns. They were questioned on quality of food, dietary preferences, and staff's ability to meet special requests. The patients and family members expressed satisfaction with the quality, food choices, and the responsiveness of the dietary department with meeting their needs. Multiple staff members were interviewed, and indicated the facility attempted to meet the nutritional needs of patients.

Three of the eleven medical records reviewed indicated concerns related to dietary needs or requests. All of the medical records contained documentation of the facility meeting the dietary needs and attempting to meet the food requests. There was documentation in the medical records of a dietician's involvement when indicated.

One record indicated a patient suffered weight loss during his hospitalization. The record documented a dietician's review of the patient's weight and nutritional status on a regular basis, as well as recommendations. The record indicated the patient had multiple medical factors that contributed to the continued weight loss and had to stop taking nutrition orally, which then required intravenous nutrition throughout the hospitalization.

In an interview on 2/24/12 at 11:45 AM, the Dietary Manager stated patient dietary needs will often be relayed by the referral facility, before the patient's admission to the facility. In addition, the Dietary Manager stated the dietician performs a nutritional needs assessment on all patients within 72 hours of admission, and special nutritional needs will be identified at that time, if not before.

It could not be determined that the facility failed to address and meet the patient's nutritional needs.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Facility staff failed to appropriately assess, monitor, and treat patients.

Nolan Hoffer, Administrator March 9, 2012 Page 5 of 7

Findings #4: An unannounced survey was completed from 2/21/12 through 2/24/12. During the complaint investigation, surveyors reviewed eleven patient records, including five records of discharged patients and six records of current patients. Administrative documents were reviewed, including hospital policies, incident reports, and documentation of patient complaints and grievances. Physical therapy and occupational therapy services were observed being provided to multiple patients. Staff and patients/family members were interviewed.

Observations were made 2/21/12 from 9:30 AM to 11:00 AM, 2/22/12 from 8:00 AM to 10:00 AM, 2/23/12 from 1:30 PM to 2:30 PM, and 2/24/12 from 8:45 AM to 10:00 AM. During these time frames, staff was observed assisting patients various details of patient care. No patients were noted to have restraints in use, and patients appeared safe, either in bed or up in chairs. Staff was observed moving about the unit, attentive to patient call lights and requests. Doors of patient rooms were closed when patients were sleeping, receiving personal cares, or when visitors were present, otherwise doors were partially open for visibility of the patient by staff members as they walked through the unit. Each room (except those in the high observation unit) had a "DAILY FLOWSHEET TREATMENT RECORD" on a clipboard that the staff used for documentation of care activities which included nutritional/intravenous intake, bowel and bladder output, position changes, safety and treatments.

One record documented an 82 year old male who was admitted to the hospital on 4/07/11. The patient had multiple medical complications as well as a tracheostomy, peripherally inserted central catheter (a long term intravenous line) and urinary catheter. During a period of disorientation, the patient was placed in bilateral wrist restraints prevent the patient from pulling out his urinary catheter, feeding tube and intravenous line. His medical record contained appropriate physician order and documentation of nursing assessments and monitoring throughout the time he was in restraints.

The medical record indicated the patient had an infection of the mouth, which resulted in white patches on his tongue. The condition is common in weak and immunocompromised patients. The physician ordered three different medications to treat the infection. The medical record contained documentation of the administration of these medications, completion of oral care, and nursing notes indicated an improvement and resolution of the infection.

The medical record contained nursing documentation of the urinary catheter leaking on several occasions. Nursing staff documented changing the catheter twice in one day in an attempt to resolve the leakage of urine.

Nursing staff documented the patient's feeding tube site was red with occasional drainage. The medical record indicated the physician was aware of the condition of the site, and a topically applied antibiotic medication had been ordered. The patient medical record contained documentation of the nursing staff assessment of the feeding tube site and administration of the

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medication as ordered.

The medical record contained documentation of pain assessments on a routine basis and the administration of pain medications as ordered and upon patient request.

It could not be determined that the facility failed to monitor and supervise disoriented patients.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: Staff failed to provide interventions in preventing skin breakdown.

Findings #5: An unannounced survey was conducted from 2/21/12 to 2/24/12. Eleven medical records were reviewed, five closed and six open. Eleven currents patients and/or their families were interviewed regarding their care. Medical records were reviewed for documentation of appropriate repositioning, skin care, wound care orders and treatment, and specialized mattresses. Patients and/or their families were interviewed regarding skin care, turning frequency, and the use of specialized mattresses.

Observations were made on 2/21/12 from 9:30 AM to 11:00 AM, 2/22/12 from 8:00 AM to 10:00 AM, 2/23/12 from 1:30 PM to 2:30 PM, and 2/24/12 from 8:45 AM to 10:00 AM on the facility's patient care unit. While observing staff responding to call lights, surveyors also checked on patients at various times to assess for position changes. Patients were found to be repositioned at appropriate intervals. Flow sheets for documenting skin cares and repositioning were in patients' rooms and were updated throughout the day.

The five closed records reviewed included documentation that indicated wounds healing, skin integrity maintained and/or improving. The six open records reviewed included documentation of scheduled repositioning every 2 hours, appropriate hygiene, use of specialty mattresses as appropriate, and physician ordered wound care.

Eleven of eleven current patients interviewed stated facility staff turned and repositioned them appropriately and per request. The patients stated staff provided appropriate wound care, skin care, repositioning, and hygiene needs to keep the patients' skin intact.

The Medical Director was interviewed regarding the use of different mattresses to prevent skin breakdown. He stated the STAT III air mattress was used for patients at high risk of developing pressure ulcers and for patients who already had pressure ulcers, while the Clinitron mattress (a mattress with sand beads blown around by a warm air fan) was used for patients recovering from a skin flap placement and who were "extremely immobile."

One medical record reviewed contained documentation of an 82 year old male admitted to the

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facility for treatment related to multiple medical conditions which impacted his ability to maintain good skin integrity. The patient was bed bound and a STAT III air mattress was ordered shortly after admission to prevent pressure ulcers and to protect skin integrity. The patient's alteration, and potential for alteration, in skin integrity were part of the plan of care. Nursing documentation indicated that the patient's skin integrity improved during his hospitalization. According to the documentation, wounds healed and the patient did not suffer from any new skin breakdown.

It could not be determined that the facility failed to prevent skin breakdown.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

AIMEE HASTRITER Health Facility Surveyor

Non-Long Term Care

SYLVIA CRESWELL

Co-Supervisor

Non-Long Term Care

AH/srm